FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042119

Facility Name: SOUTH SHORE NSG & REHAB CTR

Address: 2649 E. 75TH STREET (Number) CHICAGO (City) 60649 (Zip Code)

County: COOK

Telephone Number: (773) 356-9300 **Fax #** (773) 356-9384

IDPA ID Number: 364209295001

Date of Initial License for Current Owners: 05/28/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	69,573	3,858	7,596	81,027	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,573	3,858	7,596	81,027	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.50%

D. How many bed-hold days during this year were paid by Public Aid?
2,944 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/28/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/28/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 7,596

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	315,722	42,923	20,529	379,174		379,174	(8,064)	371,110			1
2	Food Purchase		284,628		284,628	(7,424)	277,204	4,610	281,814			2
3	Housekeeping	224,433	47,524		271,957		271,957		271,957			3
4	Laundry	104,700	31,747		136,447		136,447		136,447			4
5	Heat and Other Utilities			239,908	239,908		239,908	2,097	242,005			5
6	Maintenance	74,281		284,341	358,622		358,622	(6,141)	352,481			6
7	Other (specify):*							2,136	2,136			7
8	**TOTAL General Services**	719,136	406,822	544,778	1,670,736	(7,424)	1,663,312	(5,362)	1,657,950			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	2,547,709	103,529	12,794	2,664,032		2,664,032	14,911	2,678,943			10
10a	Therapy	84,901	3,376	11,070	99,347		99,347	1	99,348			10a
11	Activities	160,787	9,941	5,113	175,841		175,841	27	175,868			11
12	Social Services	83,015		21,961	104,976		104,976	17	104,993			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,657	5,657			15
16	**TOTAL Health Care and Programs**	2,876,412	116,846	59,188	3,052,446		3,052,446	20,613	3,073,059			16
	C. General Administration											
17	Administrative	73,647		234,801	308,448		308,448	42,731	351,179			17
18	Directors Fees											18
19	Professional Services			369,062	369,062	(409)	368,653	(312,551)	56,102			19
20	Dues, Fees, Subscriptions & Promotions			85,033	85,033		85,033	(38,216)	46,817			20
21	Clerical & General Office Expenses	141,621	24,904	518,185	684,710		684,710	(313,795)	370,915			21
22	Employee Benefits & Payroll Taxes			794,192	794,192	7,424	801,616	(55,657)	745,959			22
23	Inservice Training & Education			598	598		598		598			23
24	Travel and Seminar			3,295	3,295		3,295	1,691	4,986			24
25	Other Admin. Staff Transportation			817	817		817		817			25
26	Insurance-Prop.Liab.Malpractice			203,642	203,642		203,642	1,475	205,117			26
27	Other (specify):*							29,885	29,885			27
28	**TOTAL General Administration**	215,268	24,904	2,209,625	2,449,797	7,015	2,456,812	(644,437)	1,812,375			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,810,816	548,572	2,813,591	7,172,979	(409)	7,172,570	(629,186)	6,543,384			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR #0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			41,489	41,489		41,489	425,548	467,037			30
31	Amortization of Pre-Op. & Org.			4,017	4,017		4,017	15,373	19,390			31
32	Interest							922,661	922,661			32
33	Real Estate Taxes			318,179	318,179	409	318,588	3,640	322,228			33
34	Rent-Facility & Grounds			1,357,800	1,357,800		1,357,800	(1,352,164)	5,636			34
35	Rent-Equipment & Vehicles			3,825	3,825		3,825	4,103	7,928			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,725,310	1,725,310	409	1,725,719	19,161	1,744,880			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		290,536	350,881	641,417		641,417	(3,241)	638,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,400	131,400		131,400		131,400			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		290,536	482,281	772,817		772,817	(3,241)	769,576			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,810,816	839,108	5,021,182	9,671,106		9,671,106	(613,266)	9,057,840			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,236)	30		9
10	Interest and Other Investment Income	(138,215)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(135)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(445,000)	21		24
25	Fund Raising, Advertising and Promotional	(13,842)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(70,815)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (671,243)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	57,977		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 57,977		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (613,266)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

SOUTH SHORE NSG & REHAB CTR

ID# 0042119

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COLLECTION EXPENSE	$ (3,612)	21	1
2	BANK CHARGES	(5,420)	21	2
3	LATE FILING FEE	(114)	20	3
4	PENALTY	(500)	20	4
5	JURY DUTY	(86)	10	5
6	MISCELLANEOUS INCOME	(35)	21	6
7	THEFT LOSS	(240)	21	7
8	BANK CHARGES (BLDG CO)	(22)	21	8
9	TRUST FEES (BLDG CO)	(150)	21	9
10	LLC FEES (BLDG CO)	(300)	21	10
11	IL COUNCIL ON LTC (COPE FEES)	(3,500)	20	11
12	PENSION EXPENSE (PPA)	(43,821)	22	12
13	CAPITALIZED R & M	(12,685)	06	13
14	LEGAL FEES	(322)	19	14
15				15
16				16
17				17
18				18
19				19
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99				99
100				100
101	Total	(70,815)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary					(2,369)	(5,695)						(8,064)	1
2	Food Purchase	(135)		(181)			4,926						4,610	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,097									2,097	5
6	Maintenance	(12,685)		4,103		2,427	14						(6,141)	6
7	Other (specify):*				370	1,192	574						2,136	7
8	**TOTAL General Services**	(12,820)		6,019	370	1,250	(181)						(5,362)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(86)		(50)		15,039	8						14,911	10
10a	Therapy				1								1	10a
11	Activities			3	24								27	11
12	Social Services					17							17	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,585	2,072							5,657	15
16	**TOTAL Health Care and Programs**	(86)		(47)	3,610	17,128	8						20,613	16
	C. General Administration													
17	Administrative			494		42,012	225						42,731	17
18	Directors Fees													18
19	Professional Services	(322)		(312,681)			452						(312,551)	19
20	Fees, Subscriptions & Promotions	(17,964)		(20,277)			25						(38,216)	20
21	Clerical & General Office Expenses	(454,779)	472	20,232		119,956	324						(313,795)	21
22	Employee Benefits & Payroll Taxes	(43,821)			(11,836)								(55,657)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,207			484						1,691	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,475									1,475	26
27	Other (specify):*				7,066	22,819							29,885	27
28	**TOTAL General Administration**	(516,886)	472	(309,550)	(4,770)	184,787	1,510						(644,437)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(529,792)	472	(303,578)	(790)	203,165	1,337						(629,186)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,236)	414,326	14,458									425,548	30
31	Amortization of Pre-Op. & Org.		15,373										15,373	31
32	Interest	(138,215)	1,045,456	15,420									922,661	32
33	Real Estate Taxes			3,640									3,640	33
34	Rent-Facility & Grounds		(1,357,800)	5,623			13						(1,352,164)	34
35	Rent-Equipment & Vehicles			4,085			18						4,103	35
36	Other (specify):*													36
37	TOTAL Ownership	(141,451)	117,355	43,226			31						19,161	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,241)						(3,241)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(3,241)						(3,241)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(671,243)	117,827	(260,352)	(790)	203,165	(1,873)						(613,266)	45

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Properties, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 1,357,800	SOUTH SHORE PROPERTIES, LLC.	100.00%	$	$ (1,357,800)	1
2	V	32	INTEREST EXPENSE		SOUTH SHORE PROPERTIES, LLC.	100.00%	1,045,456	1,045,456	2
3	V	21	BANK CHARGES		SOUTH SHORE PROPERTIES, LLC.	100.00%	22	22	3
4	V	21	TRUST FEES		SOUTH SHORE PROPERTIES, LLC.	100.00%	150	150	4
5	V	31	AMORTIZATION		SOUTH SHORE PROPERTIES, LLC.	100.00%	15,373	15,373	5
6	V	30	DEPRECIATION		SOUTH SHORE PROPERTIES, LLC.	100.00%	414,326	414,326	6
7	V	21	LLC FEE		SOUTH SHORE PROPERTIES, LLC.	100.00%	300	300	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,357,800			$ 1,475,627	$ * 117,827	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 2,097	$ 2,097	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	4,103	4,103	16
17	V	10	Nursing	60	Care Centers, Inc.	100.00%	10	(50)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	3	3	18
19	V	19	Professional Fees	324,900	Care Centers, Inc.	100.00%	12,219	(312,681)	19
20	V	20	Dues and Subscriptions	21,900	Care Centers, Inc.	100.00%	1,623	(20,277)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	20,232	20,232	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	1,207	1,207	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	1,475	1,475	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	14,458	14,458	24
25	V	32	Interest		Care Centers, Inc.	100.00%	15,420	15,420	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,640	3,640	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,623	5,623	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	4,085	4,085	28
29	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			29
30	V	02	Food	181	Care Centers, Inc.	100.00%		(181)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	494	494	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,041			$ 86,689	$ * (260,352)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary	2,819	Care Centers, Inc.	100.00%	2,819		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	370	370	17
18	V	10	Nursing Salary	6,866	Care Centers, Inc.	100.00%	6,866		18
19	V	10a	Rehab Salary	647	Care Centers, Inc.	100.00%	648	1	19
20	V	11	Activity Salary	4,345	Care Centers, Inc.	100.00%	4,369	24	20
21	V	12	Social Service Salary	12,357	Care Centers, Inc.	100.00%	12,357		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,585	3,585	22
23	V	17	Administration Salary	18,801	Care Centers, Inc.	100.00%	18,801		23
24	V	21	Office Salary	33,074	Care Centers, Inc.	100.00%	33,074		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	7,066	7,066	25
26	V	22	Employee Benefits	11,836	Care Centers, Inc.	100.00%		(11,836)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,745			$ 89,955	$ * (790)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,760	Care Centers, Inc.	100.00%	$ 6,391	$ (2,369)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,427	2,427	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,192	1,192	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	15,039	15,039	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	17	17	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,072	2,072	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	42,012	42,012	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	119,956	119,956	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	22,819	22,819	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,760			$ 211,925	$ * 203,165	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 11,750	Care Centers, Inc. - Health Systems Division	100.00%	$ 1,784	$ (9,966)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	4,926	4,926	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	14	14	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	8	8	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	225	225	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	452	452	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	25	25	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	324	324	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	484	484	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	13	13	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	18	18	25
26	V	39	Ancillary Enteral Supplies	7,298	Care Centers, Inc. - Health Systems Division	100.00%	4,057	(3,241)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	4,271	4,271	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	574	574	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 19,048			$ 17,175	$ * (1,873)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 143,776	$ 143,776	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	143,776				(143,776)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,776			$ 143,776	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	David Aronin	Owner	Administrative	0.83%	See Attached	2.47	4.94%	CCI Salary	$ 4,271	17-7	1
2	Sandy Bokor	Relative	Administrative	0.00%	See Attached	1	2.00%	Mgmt Fees	12,000	17-3	2
3	Melissa Rothner	Owner	Clerical	1.88%	See Attached			CCI Salary	50	21-7	3
4	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.47	4.94%	CCI Salary	2,236	17--7	4
5	Alan Abrams	Owner	Administrative	8.33%	See Attached	1	2.86%	Mgmt Fees	12,000	17-3	5
6	Ron Abrams	Owner	Administrative	8.33%	See Attached	1	2.86%	Mgmt Fees	12,000	17-3	6
7	Eric Rothner	Relative	Administrative	0.00%	See Attached	2.42	3.36%	Mgmt Fees	180,000	17-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 222,557		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	81,027	$ 2,097	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		81,027	4,103	2
3	10	Nursing	Patient Days	1,640,756	39	205		81,027	10	3
4	11	Activities	Patient Days	1,640,756	39	51		81,027	3	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		81,027	12,219	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		81,027	1,623	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		81,027	20,232	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		81,027	1,207	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		81,027	1,475	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		81,027	14,458	10
11	32	Interest	Patient Days	1,640,756	39	312,254		81,027	15,420	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		81,027	3,640	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		81,027	5,623	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		81,027	4,085	14
15	17	Administration	Patient Days	1,640,756	39	10,000		81,027	494	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 86,689	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		2,819	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			370	3
4	10	Nursing Salary	Direct Cost			895,582	895,582		6,866	4
5	10a	Rehab Salary	Direct Cost			128,376	128,376		648	5
6	11	Activity Salary	Direct Cost			57,201	57,201		4,369	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		12,357	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			3,585	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		18,801	9
10	21	Office Salary	Direct Cost			584,278	584,278		33,074	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			7,066	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 89,955	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	81,027	6,391	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	81,027	2,427	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		81,027	1,192	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	81,027	15,039	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	81,027	17	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		81,027	2,072	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	81,027	42,012	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	81,027	119,956	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		81,027	22,819	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 211,925	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		21,426	1,784	1
2	02	Food	Billable Income	2,191,458		834,365		21,426	4,926	2
3	06	Maintenance	Billable Income	2,191,458		1,400		21,426	14	3
4	10	Nursing	Billable Income	2,191,458		850		21,426	8	4
5	17	Administration	Billable Income	2,191,458		23,000		21,426	225	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		21,426	452	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		21,426	25	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		21,426	324	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		21,426	484	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		21,426	13	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		21,426	18	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		21,426	4,057	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	21,426	4,271	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		21,426	574	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 17,175	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 143,776	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 143,776	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CORUS BANK			MORTGAGE (BLDG CO)			$	$ 9,863,376			$ 741,115	1
2	CIB BANK			MORTGAGE (BLDG CO)				3,506,950			290,399	2
3												3
4												4
5												5
	Working Capital											
6	DAIWA LOAN		x								13,942	6
7												7
8												8
9	TOTAL Facility Related						$	$ 13,370,326			$ 1,045,456	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(122,795)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (122,795)	14
15	TOTALS (line 9+line14)						$	$ 13,370,326			$ 922,661	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Care Center, Inc. Allocation						$	$			$ 15,420	1
2	Interest Income										(138,215)	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (122,795)	21

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	357,088	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	335,799	2
3. Under or (over) accrual (line 2 minus line 1).	$	(21,289)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	343,109	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	409	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	322,229	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	108,397	9
1999	266,137	10
2000	324,625	11
2001	332,159	12

2002 Accrual = $332,159-5,388=$326,771 326,771*1.05=$343,109

Legal Invoice-$409.00

Allocation from Care Centers Inc. - 3,640

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTH SHORE NSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attached	Home Office Allocation	$ 70,262.00	$ 3,469.80
2.	21-30-200-008-0000	Long Term Care Property	$ 50,992.50	$ 50,992.50
3.	21-30-200-001-0000	Long Term Care Property	$ 272,189.96	$ 272,189.96
4.	21-30-200-002-0000	Long Term Care Property	$ 3,587.70	$ 3,587.70
5.	21-30-121-008-0000	Long Term Care Property	$ 3,424.79	$ 3,424.79
6.	21-30-121-009-0000	Long Term Care Property	$ 1,963.61	$ 1,963.61
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 402,420.56	$ 335,628.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTH SHORE NSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 115,306
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 19,390
4. Dates Incurred: Various

Nature of Costs: Financing Fees, Closing Costs, Loan Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	101,000	1994	$ 352,000	1
2	Allocation from Care Centers				2
3	TOTALS	101,000		$ 352,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	22,697		20	1,135	1,135	4,890	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		11,778,946	337,035		337,598	563	1,497,673	68
69	Financial Statement Depreciation			14,515			(14,515)		69
70	TOTAL (lines 4 thru 69)		$ 11,801,643	$ 351,550		$ 338,733	$ (12,817)	$ 1,502,563	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,801,643	$ 351,550		$ 338,733	$ (12,817)	$ 1,502,563	1
2	SIGN	1999	2,240		20	112	112	411	2
3	A/C UPGRADE	1999	3,800		20	190	190	697	3
4	WIRING	1999	13,000		20	650	650	2,058	4
5	HVAC RENOV	1999	1,796		20	90	90	278	5
6	ADDL BLDG LEGAL FEES	1999	1,953		20	98	98	294	6
7	BOILER RENOV	2000	967		20	48	48	144	7
8	TV WIRING	2000	18,268		20	913	913	2,663	8
9	CABLING	2000	952		20	48	48	136	9
10	PLUMBING RENOV	2000	894		20	45	45	124	10
11	WATER HEATER	2000	9,417		20	471	471	1,295	11
12	HVAC	2000	4,562		20	228	228	589	12
13	HVAC	2000	5,908		20	295	295	787	13
14	ELEVATOR PARTS	2000	558		20	28	28	68	14
15	HOT WATER HEATER	2001	3,980		20	199	199	398	15
16	FAN POWER BOX	2001	589		20	29	29	56	16
17	EXIT SIGN	2001	2,336		20	117	117	205	17
18	CHILLER BUNDLE	2001	2,020		20	101	101	168	18
19	SPRINKLER SYSTEM	2001	1,405		20	70	70	111	19
20	CYLLANDER ASSY	2001	2,394		20	120	120	170	20
21	BYPASS ON WATER HEAT	2001	2,146		20	107	107	143	21
22	BOILER	2001	4,000		20	200	200	250	22
23	TUBE SECTIONS	2001	6,074		20	304	304	380	23
24	BOILER REPAIR	2001	3,340		20	167	167	195	24
25	BOILER	2001	851		20	43	43	50	25
26	BOILER REPAIR	2001	10,192		20	510	510	595	26
27	POWER WC REPAIR	2001	575		20	29	29	34	27
28	TILES	2001	1,550		20	78	78	156	28
29	BOILER REPAIR	2001	1,676		20	84	84	119	29
30	MOTOR	2002	582		20	49	49	49	30
31	WATER TREATMENT	2002	1,692		20	118	118	118	31
32	CABLE LINES	2002	518		20	35	35	35	32
33	CABLE LINES	2002	1,025		20	68	68	68	33
34	TOTAL (lines 1 thru 33)		$ 11,912,903	$ 351,550		$ 344,377	$ (7,173)	$ 1,515,407	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,912,903	$ 351,550		$ 344,377	$ (7,173)	$ 1,515,407	1
2	CHILLER	2002	890		20	59	59	59	2
3	DINING ROOM RENOV	2002	17,195		20	860	860	860	3
4	PLUMBING	2002	689		20	17	17	17	4
5	PHONES	2002	954		20	16	16	16	5
6	SEPTIC	2002	1,910		20	32	32	32	6
7	PUMP MOTOR	2002	1,100		20	9	9	9	7
8	WATER TREATMENT SYSTEM	2002	1,004		20	42	42	42	8
9	WINDOW TREATMENTS	2002	650		20	38	38	38	9
10	LOCKS	2002	508		20	51	51	51	10
11	CHILLER	2002	8,760		20	219	219	219	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,946,563	$ 351,550		$ 345,720	$ (5,830)	$ 1,516,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI Allocation			1996	$	$ 1,315	35	$ 1,465	$ 150	$	4
5	CCI Allocation			2002	26,624	54	35	80	26		5
6	240		1998	1998	11,715,725	334,735	35	334,735		1,495,653	6
7											7
8											8
	Improvement Type**										
9	Allocation from Care Centers Inc.			2002		488	20	33	(455)		9
10	Allocation from Care Centers Inc.			2001		1	20	7	6		10
11	Allocation from Care Centers Inc.			2000		2	20	3	1		11
12	Allocation from Care Centers Inc.			1999		24	20	46	(22)		12
13	Allocation from Care Centers Inc.			1998		10	20	19	9		13
14	Allocation from Care Centers Inc.			1997		94	20	189	95		14
15	Allocation from Care Centers Inc.			1996		245	20	375	130		15
16	Allocation from Care Centers Inc.			Indiana		1	20	31	30		16
17	Allocation from Care Centers Inc.			1994		12	20		(12)		17
18	Allocation from Care Centers Inc.			1993		5	20		(5)		18
19											19
20	Allocation from Care Centers Inc.			2002	26,503	49	20	110	61		20
21											21
22											22
23											23
24	Fence-South Shore Building Company			1998	10,094	-	20	505	505	2,020	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,778,946	$ 337,035		$ 337,598	$ 519	$ 1,497,673	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,069,727	$ 111,291	$ 113,340	$ 2,049	10	$ 521,749	71
72	Current Year Purchases	34,505	1,835	3,129	1,294	10	3,129	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,104,232	$ 113,126	$ 116,469	$ 3,343		$ 524,878	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Center Allocation	AUTO		$ 33,268	$ 5,597	$ 4,848	$ (749)	5	$ 18,193	76
77										77
78										78
79										79
80	TOTALS			$ 33,268	$ 5,597	$ 4,848	$ (749)		$ 18,193	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,436,063	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 470,273	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 467,037	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,236)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,059,821	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		ALLOCATION FROM CARE CENTERS, INC.			5,636			6
7	TOTAL				$ 5,636 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,928 Description: COPIERS-$3641; POSTAGE METER-$183; Care Center Allocation-$4,103
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 145,626	$		$ 145,626	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,306			4,306	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			200,949			200,949	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				165,158		165,158	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						125,378		125,378	13
14	TOTAL			$		$ 350,881	$ 290,536		$ 641,417	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,004	$ 5,934	1
2	Cash-Patient Deposits	88,405	88,405	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,994,731	1,994,731	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	266,062	266,062	6
7	Other Prepaid Expenses	936	936	7
8	Accounts Receivable (owners or related parties)	1,048,321	1,048,321	8
9	Other(specify): See Supplemental Schedule	3,329,915	3,329,915	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,731,374	$ 6,734,304	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		12,209,725	14
15	Leasehold Improvements, at Historical Cost	149,926	149,926	15
16	Equipment, at Historical Cost	164,823	1,043,778	16
17	Accumulated Depreciation (book methods)	(133,059)	(2,383,523)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	703	71,974	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 182,393	$ 11,443,880	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,913,767	$ 18,178,184	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 895,805	$ 895,806	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	83,168	83,168	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	200,905	200,905	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,437	26,437	31
32	Accrued Real Estate Taxes(Sch.IX-B)	343,109	343,109	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,532	3,532	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	33,135	1,117,615	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,586,091	$ 2,670,572	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		248,321	39
40	Mortgage Payable		13,122,005	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,370,326	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,586,091	$ 16,040,898	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,327,676	$ 2,137,286	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,913,767	$ 18,178,184	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,576,314	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,576,314	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,931,362	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(180,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,751,362	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,327,676	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,180,034	1
2	Discounts and Allowances for all Levels	(2,146,499)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,033,535	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,942,000	6
7	Oxygen	34,112	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,976,112	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	206,021	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,807	19
20	Radiology and X-Ray	3,250	20
21	Other Medical Services	220,408	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 454,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	138,215	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 138,215	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	120	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 120	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,602,468	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,670,736	31
32	Health Care	3,052,446	32
33	General Administration	2,449,797	33
	B. Capital Expense		
34	Ownership	1,725,310	34
	C. Ancillary Expense		
35	Special Cost Centers	641,417	35
36	Provider Participation Fee	131,400	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,671,106	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,931,362	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,931,362	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,603	1,778	$ 55,564	$ 31.25	1
2	Assistant Director of Nursing	2,499	2,699	64,065	23.74	2
3	Registered Nurses	13,752	14,999	283,976	18.93	3
4	Licensed Practical Nurses	52,702	56,455	1,010,060	17.89	4
5	Nurse Aides & Orderlies	116,627	127,173	1,077,738	8.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,808	7,469	84,901	11.37	8
9	Activity Director	1,825	2,265	35,467	15.66	9
10	Activity Assistants	15,968	16,997	125,320	7.37	10
11	Social Service Workers	8,469	9,323	83,015	8.90	11
12	Dietician	1,895	2,015	21,668	10.75	12
13	Food Service Supervisor	3,875	4,255	56,376	13.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,617	32,470	237,678	7.32	15
16	Dishwashers					16
17	Maintenance Workers	5,816	6,540	74,281	11.36	17
18	Housekeepers	30,069	31,901	224,433	7.04	18
19	Laundry	14,145	14,986	104,700	6.99	19
20	Administrator	1,116	1,321	37,626	28.48	20
21	Assistant Administrator	1,116	1,321	36,021	27.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,802	16,312	141,621	8.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,284	5,795	56,306	9.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	330,988	356,076	$ 3,810,816 *	$ 10.70	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	289	$ 11,769	01-03	35
36	Medical Director	Monthly	8,250	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant	128	6,890	10a-03	40
41	Occupational Therapy Consultant	65	3,533	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	768	11-03	44
45	Social Service Consultant		12,357	12-03	45
46	Other(specify)				46
47	Care Center Salary		30,222	Various	47
48					48
49	TOTAL (lines 35 - 48)	498	$ 79,717		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Williams (01/02-06/02)	Asst Administrator	0	$ 36,021
Elizabeth Williams (07/02-12/02)	Administrator		37,626
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,647

B. Administrative - Other

Description	Amount
Administrator Salary CCI	$ 18,801
Management Fees	216,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 234,801
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS	UNEMPLOYMENT CONSU	$ 2,040
CARE CENTER, INC	VARIOUS	324,900
FR&R	ACCOUNTING	16,660
(SEE ATTACHED)	LEGAL	3,210
(SEE ATTACHED)	OTHER PROFESSIONAL	13,188
IIT/SOURCE TECH	COMPUTER	815
MAXXSOURCE	COMPUTER	1,100
ALPHA DATA	COMPUTER	6,549
OMNICARE	COMPUTER	600
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 369,062

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,687
Unemployment Compensation Insurance	66,564
FICA Taxes	287,159
Employee Health Insurance	200,239
Employee Meals	7,424
Illinois Municipal Retirement Fund (IMRF)*	
PENSION EXPENSE	14,807
CHICAGO HEAD TAX	16,088
MISC EMPL WELL	2,766
DRUG TEST KIT	5,226
TOTAL (agree to Schedule V, line 22, col.8)	$ 745,960

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	20,000
Health Care Worker Background Check	
(Indicate # of checks performed 100)	1,000
DUES AND SUBSCRIPTIONS	7,995
LICENSES & FEES	6,210
CLASSIFIED ADVERTISING	9,765
ADVERTISING & PROMOTION	35,742
ALLOCATION FROM CARE CENTERS	1,648
Less: Public Relations Expense	( )
Non-allowable advertising	(35,742)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,817

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,115
ALLOCATION FROM CARE CENTERS	1,691
EDUCATIONAL EXPENSE	2,180
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,986

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on Long Term Care $11493.20**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,580** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **131,400**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,424** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees